## Question 1: What client information do you need in order to plan and deliver care?

| | Who is this information important to … | | | | |
|---|---|---|---|---|---|
| ***Information that is critical to plan and deliver care*** | Client/ Family | Home Care | Facility | Cont Care | Other |
| social history (summary) | | | x | x | |
| medical history (summary) | | | x | x | |
| assessment tools | | | | | |
| health card number | | | | | |
| family supports | | | | | |
| level of independence with ADL/equipment | | | | | |
| cognitive status | | | | | |
| social/family history | | | | | |
| past medical history/medications | | | | | |
| Behaviours | | | | | |
| standardized medical reconciliation | x | | x | | |
| client status while client in hospital not being relayed to facility | | | | | |
| communication back from ER when resident return to facility (RISK). | | | | | |
| To retain our relationship with our partners like Acute Care and family to reduce risk. Also a breach of nursing standards. | | | | | |
| demographics-what, where, ???, DOB | | | | | |
| safety and security vs privacy -what is the balance? | | | | | |
| no sharing of information between service providers-Home Care to LTC | | | | | |
| History-social to ???, care, wounds, risks | | | | | |
| Mental health/illness-access to history/treatment | | | | | |
| Lack of tools from InterRAI-score Maple etc. | | | | | |
| Expertise to support specialized care (pressure injury, mental health) | | | | | |
| relevant/current-it is not always up-to-date, nursing home now reassessing prior to admission, delays admission | | x | x | | |
| equipment needs-are they indicated in assessment and are they available upon admission | | x | x | | |
| access to resources ie wound care consultant | | x | x | | |
| Family dynamics are complex background on family issues/concerns coming in i.e. expectation loved one is full code? | | x | x | | |
| Access to reports i.e. mental health assessments as part of background | | | x | x | |
| LTC: current physical, social, identifying challenges, nutritional info, updated info between LTC facilities | | | x | x | |

| | | | | | |
|---|---|---|---|---|---|
| Competency, adult protection involvement | | x | | x | |
| support systems in place | | x | x | x | |
| Medical reconciliations | | x | | | |
| transfer summary tool acute care to community organization | | x | | x | |
| back up plans | | x | | x | |
| not all about care-its reality of life | | | | | |
| Behaviours - creating a safe space for clients and staff-triggers or ???? That exacerbate this. What is their day to day like? Past behaviour? | | | | | |
| Items that comfort the client. Psycho/social. What have the last four weeks been like? Outside the hospital? | | | | | |
| Social skills/hobbies/communication-likes/dislikes | | | | | |
| How much information the resident has on what's happening | | | | | |
| Medical information ??? From hospital in it's the social/psy. Standardized package that family could fill out and reverse what to expect from LTC? | | | | | |
| Medical history (active, current care issues, dx) | | | | | |
| support network | | | | | |
| daily routine and preferences | | | | | |
| risks/safety concerns | | | | | |
| Primary diagnosis re needs required/history | x | x | x | x | |
| informal supports already existing | | x | x | x | |
| client behaviour/safety concerns | | x | x | x | |
| client/sdm wishes re needs | | x | x | x | |
| options/services available in community | x | | | | |

## Question 2: How can we use this information to <u>reduce the amount of repetition</u> for clients and families?

| Client/Family | Continuing Care | Home Care | Facility | Other |
|---|---|---|---|---|
| clear who is SDM?<br>Answer family dynamics | | | | |
| Integrate interRAI<br>information across organizations | | | | |
| Up to date assessments<br>especially between transfers | | | | |

## Question 3: How can we use this information in our practice to <u>improve care planning</u> for better outcomes for clients?

| | Client/ Family | Continuing Care | Home Care | Facility | Other |
|---|---|---|---|---|---|
| stigma of behavioural issues-so not revealed by family. Ex. Elopement risk-applies across all organizations | | | | Provide information<br>that considers licensing requirements of the facility<br>i.e. 12 assessments within two weeks for each new resident (OT, Rec) | |
| Share with partners, make information available to all care partners, open and honest dialogue, pass on success, challenges | x | x | x | xx | |